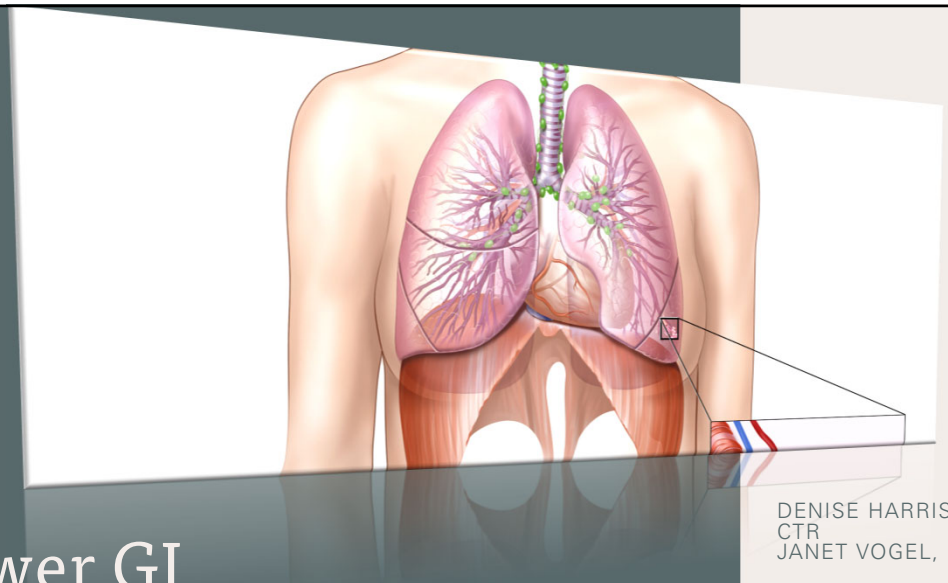


Lower GI 2023 Part 2

DENISE HARRISON, CTR
JANET VOGEL, CTR

6/1/2023

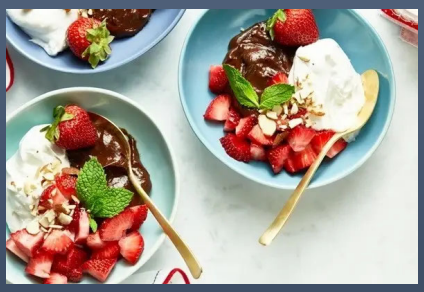
Q&A

Please submit all questions concerning the webinar content through the Q&A panel.

If you have participants watching this webinar at your site, please collect their names and emails.

We will be distributing a Q&A document in about one week. This document will fully answer questions asked during the webinar and will contain any corrections that we may discover after the webinar.

Fabulous Prizes



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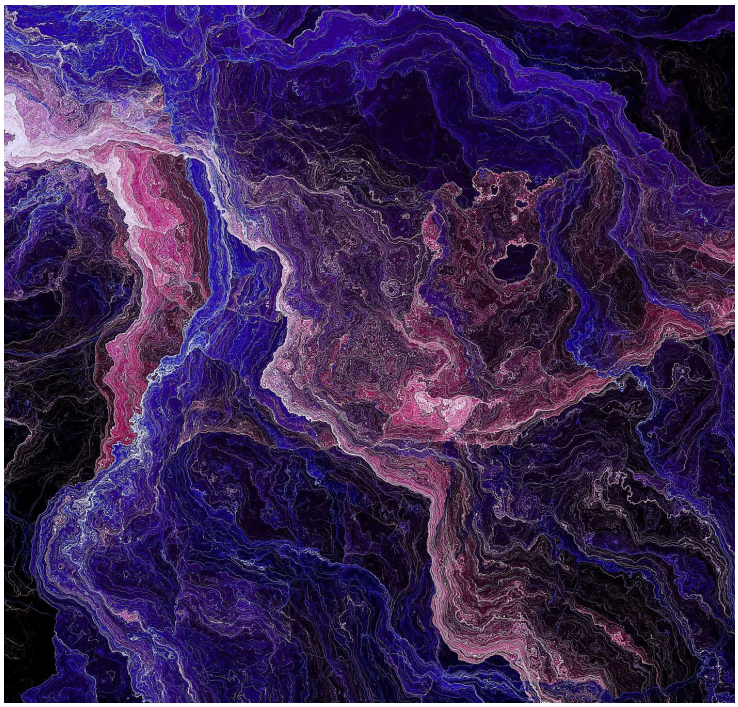
Guest Presenter

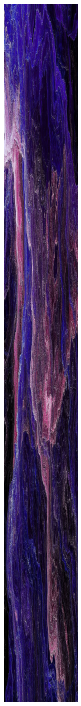
- Denise Harrison, CTR
  - Education Board Director, NCRA
- Janet Vogel, CTR
  - Compliance and Quality Auditor/Educator – Cancer Registry, Omega Healthcare

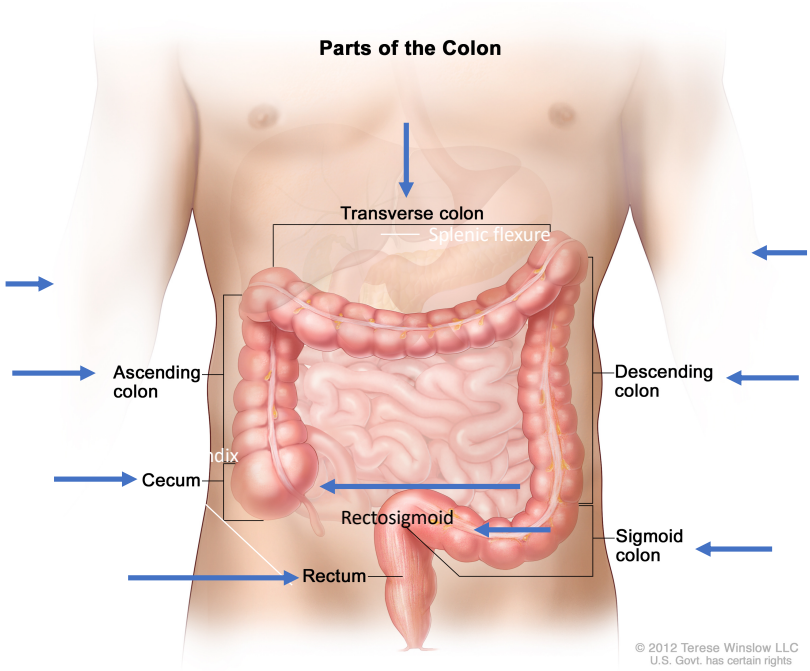
4

Staging Colorectal and Appendiceal Cancers

- *Surgery*
- *Summary Stage 2018*
- *EOD*
- *AJCC*

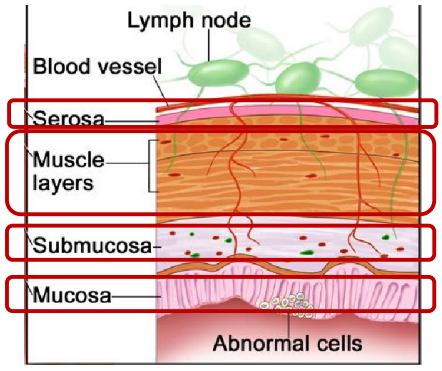






Colon/Appendix Wall Layers

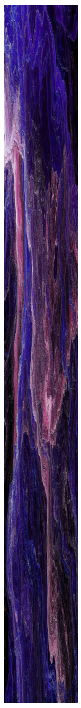
Mucosa includes:
- Epithelium
- Lamina propria
- Muscularis mucosa



http://www.cancer.gov

Poll 1 – Surgical Diagnostic & Staging Procedure

- **Scenario**:
  - 2022 Screening colonoscopy is + for adenocarcinoma in sigmoid colon
- **Question**: How would you code the Surgical Diagnostic and Staging Procedure?
  - **A. 02** A biopsy (incisional, needle, or aspiration) was done to the primary site; or biopsy or removal of a lymph node to diagnose or stage lymphoma
  - **B. 05** An exploratory procedure was performed, and a biopsy of either the primary site or another site was done



Poll 1 – Answer & Rationale
Surgical Diagnostic & Staging Procedure

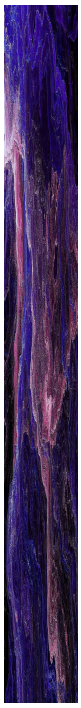
- **Answer: 02** A biopsy (incisional, needle, or aspiration) was done to the primary site; or biopsy or removal of a lymph node to diagnose or stage lymphoma

- **Rationale:** The screening colonoscopy was performed to screen for colon cancer; an area of concern was biopsied during the procedure. Since a biopsy was done to the primary site, assign code **02**.

Poll 2 – Surgical Diagnostic & Staging Procedure

- **Scenario**:
  - 2023 Screening colonoscopy w/ bx of ascending colon polyp; path is + for a tubular adenoma; Laparoscopic Right Colectomy + moderately differentiated adenocarcinoma invades submucosa 18 nodes (-) pT1 pN0

- **Question**: How would you code the Surgical Diagnostic and Staging Procedure?
  - **A. 00** No surgical diagnostic or staging procedure
  - **B. 02** A biopsy (incisional, needle, or aspiration) was done to the primary site; or biopsy or removal of a lymph node to diagnose or stage lymphoma
  - **C. 05** An exploratory procedure was performed, and a biopsy of either the primary site or another site was done



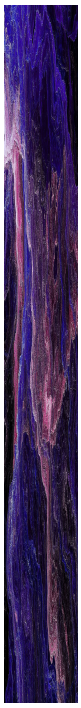
Poll 2 – Answer & Rationale
Surgical Diagnostic & Staging Procedure

- **Answer: 00** No surgical diagnostic or staging procedure

- **Rationale:** Per STORE p. 141 "Only record **positive** procedures. For benign and borderline reportable tumors, report the biopsies positive for those conditions. For malignant tumors, report procedures if they were positive for malignancy."

Rectum Surgery Codes A300 – A700

Code and Description
A300 Wedge or segmental resection; partial proctectomy, NOS
Anterior resection
Hartmann operation
Low anterior resection (LAR)
Transsacral rectosigmoidectomy
A400 Pull through WITH sphincter preservation (colo-anal anastomosis)
A500 Total proctectomy
Abdominoperineal resection
A600 Total proctocolectomy, NOS
A700 Proctectomy or proctocolectomy with resection in continuity with other organs; pelvic exenteration



Poll 3 – Surgery LAR

- **Scenario:** 2023 rectal primary
  - Laparoscopic low anterior resection: large polyp mass found in the rectum - resected from low rectum to lower sigmoid colon with anastomosis and creation of protective loop colostomy
  - Snip from PATH report: Macroscopic Evaluation of Mesorectum : Complete

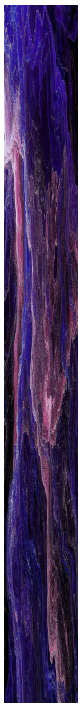
- **Question:** How would you code the Cancer Directed Surgery?

  A. A300 Segmental resection; partial proctectomy, NOS

  B. A500 Total proctectomy

Poll 3 – Answer & Rationale Surgery LAR

- Answer: A300
- STORE/SEER
  - A300 Segmental resection; partial proctectomy, NOS
    - Procedures coded A300 include, but are not limited to:
      - Anterior resection
      - Hartmann's operation
      - **Low anterior resection (LAR)**
      - Transsacral rectosigmoidectomy
- Macroscopic Evaluation of the Mesorectum – 30 Complete



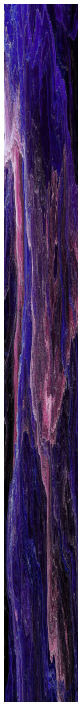
Poll 4 – Surgery AP Resection

- **Scenario:** 2023 low rectal primary within 3cm of anal verge
  - Presents with a cT3 cN2b cM0 Stage 3C low rectal primary treated with neoadjuvant chemo/radiation
  - AP Resection – removal of rectum, rectosigmoid and anus - creation of Colostomy, 14/17 nodes+
  - Snip from PATH report: Macroscopic Evaluation of Mesorectum: Near complete
- **Question:** How would you code the Cancer Directed Surgery?
  A. A300 Segmental resection; partial proctectomy, NOS
  B. A400 Pull through WITH sphincter preservation (coloanal anastomosis)
  C. A500 Total proctectomy

Poll 4 – Answer & Rationale Surgery AP Resection

- A500 Total proctectomy
- SEER Site-specific Modules » Colorectal Cancer » Treatment » Types of Surgery: Rectum https://training.seer.cancer.gov/colorectal/treatment/rectum.html
  - *"AP Resections — how to tell what the initials mean"*
    - *The general guideline is to look at the location of the tumor: if it is below 5 cm from the anal verge, AP probably stands for Abdominoperineal; if it is above 5 cm, it probably means Anterior/Posterior."*
    - *"Abdominoperineal resection is performed for very low lesions in the rectum (lower third—within 5 cm of anal verge). An abdominoperineal resection, in addition to removing the entire rectum, most of the sigmoid colon, the mesocolon and its regional lymph nodes, removes the anal sphincter and leaves the patient with a permanent colostomy."*
- SEER/STORE A500 Total proctectomy
  - Procedure coded A500 includes, but is not limited to:
    - **Abdominoperineal resection**
- Macroscopic Evaluation of the Mesorectum- 20 Nearly Complete

Staging Colorectal Cancers



EOD Primary Tumor 000-050; SS 0, 1 (SS code when no LNs and no Mets)

Code	Colon and Rectum	Appendix v9	
EOD 000 **SS** 0	In situ: Noninvasive; intraepithelial; (Adeno)CA, noninvaisve in a polyp or adenoma		
	→		HAMN confined by the muscularis propria
EOD 050 **SS** 1	Intramucosal, NOS Lamina propria Mucosa, NOS Confined to, but not through muscularis mucosa	**EOD** 050 **SS** 0	LAMN confined to the muscularis propria Acellular mucin or mucinous epithelium may invade into muscularis propria

Note 1 (EOD): Code 000 (both schema) intraepithelial/behavior code 2; includes HAMN confined to muscularis propria in Appendix schema

Note 2 (EOD): Code 050 in the **Colon and Rectum** schema is behavior code **3**

Note 2 (EOD) : Code 050 is for LAMN confined to muscularis propria in the **Appendix** schema is behavior code **2.**

EOD Primary Tumor 070 - 100; SS 1

SS	EOD	Colon and Rectum	Appendix v9
1	070		Lamina propria Mucosa (intramucosal, NOS) Muscularis mucosae
	100	Submucosa (superficial invasion)	Submucosa
		Through muscularis mucosa, but not into muscularis propria	
		Confined to polyp (head, stalk, NOS)	Confined to polyp
		Confined to colon, rectum (w/ or w/o intraluminal extension to colon anal canal/anus), rectosigmoid, NOS	Confined to appendix, NOS
		Localized, NOS	

Note 3 (EOD): Code 070 (**behavior code 3**) includes the following: Intramucosal, NOS, Lamina propria, Mucosa, NOS, Confined to, but not through the muscularis mucosa

EOD Primary Tumor 200; SS 2

SS	EOD	Colon and Rectum	Appendix v9
2	200	Muscularis propria invaded Rectum: W/ or W/O/ intraluminal extension to colon/anal canal/anus	Muscularis propria invaded (Does NOT apply to HAMN or LAMN classified in lower EOD/SS codes)

Note 3: Colon and Rectum/ **Note 4:** Appendix:
Ignore intraluminal extension to adjacent segment(s) of colon/rectum or to the ileum from the cecum; code depth of invasion or extracolonic spread as indicated.

EOD Primary Tumor 300; SS 1

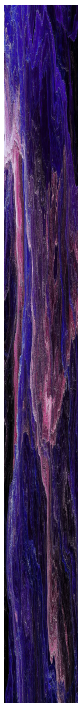
Colon and Rectum	Appendix
Extension through wall, NOS	
Invasion through muscularis propria or muscularis, NOS	
Rectum: W/ or W/O/ intraluminal extension to colon/anal canal/anus	
Non-peritonealized pericolic/perirectal tissues invaded (For colon and rectum, includes unknown if peritonealized)	
Perimuscular tissue invaded	
Subserosal tissue/(sub)serosal fat invaded	
Transmural, NOS	
Wall, NOS	

Note 6 (7 in SS): Invasion into "pericolonic/pericolorectal tissue" can be either code 300 (1) or 400 (2), depending on the primary site and whether it is peritonealized (fully or partially) or not. When extension is described as "pericolonic/pericolorectal tissue" (many more instructions in the note).

17

EOD Primary Tumor 400; SS 2

Colon and Rectum	Appendix
Adjacent (connective) tissue(s), NOS	Adjacent tissue(s), NOS; Connective tissue
Fat, NOS	
Transverse colon and flexures only Gastrocolic ligament Greater omentum	
Mesentery; Mesenteric fat	
Mesocolon	Mesoappendix
Rectovaginal septum (Rectum only)	
Retroperitoneal fat (A & D Colon only)	
For **peritonealized** sites:	
Pericolic fat/tissues	Pericolic fat
Perirectal fat/tissues	

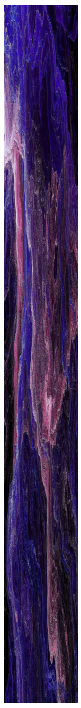


Non-Peritonealized vs Peritonealized Surfaces Summary of Note 5 (EOD)/6 (SS)

Subsite		Non-Peritonealized Surface(s)	Peritonealized Surface(s)
Cecum			All surfaces
Ascending colon		*Posterior*	*Anterior and lateral*
Hepatic flexure		*Posterior*	*Anterior and lateral*
Transverse colon			All surfaces
Splenic flexure		*Posterior*	*Anterior and lateral*
Descending colon		*Posterior*	*Anterior and lateral*
Sigmoid colon			All surfaces
Rectosigmoid colon			All surfaces
Rectum	*Upper*	*Posterior*	*Anterior and lateral*
	Middle	*Posterior*	*Anterior*
	Lower	All surfaces	

Poll 5 – Pericolonic/Pericolorectal tissue Invaded Regional or Local

- **Scenario:**
  - pT3 pN0 cM0 Stage IIA Transverse Colon adenocarcinoma with extension through the wall into pericolic tissue, 16 nodes (-), no mets on CT.
- **Question:** How would you code Summary Stage 2018?
  A. 1 Localized only (localized, NOS)
  B. 2 Regional by direct extension only



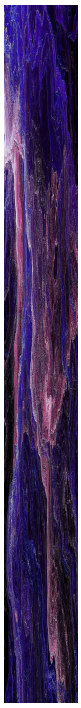
Poll 5– Answer & Rationale Pericolonic/Pericolorectal tissue Invaded-Reg or Local

- **Answer:** 2 Regional by direct extension only
- Summary Stage 2018- READ THE NOTES!
- Note 7: Invasion into "pericolonic/pericolorectal tissue" can be either localized (code 1) or regional (code 2), depending on the primary site and whether it is peritonealized (fully or partially) or not. **When extension is described as "pericolonic/pericolorectal tissue"**
  - **Localized may NOT be used for entirely peritonealized sites** (cecum, **transverse colon**, sigmoid colon, rectosigmoid colon), as this would be equivalent to peritonealized pericolic/perirectal tissue invasion (regional, code 2)
  - Localized may ONLY be used for peritonealized sites (See Note 6) when the extension is described using other terms listed under localized (code 1) (ex. subserosal fat). If there are no other terms used to describe the extension, other than invasion of "pericolorectal tissue", then assign regional (code 2)

Poll 6 – Pericolonic/Pericolorectal tissue Invaded-Reg or Local

- **Scenario:**
  - pT3 pN0 cM0 Stage IIA Ascending Colon with Extension through the wall into pericolic tissue, 16 nodes (-), no mets on CT.

- **Question**: How would you code Summary Stage 2018?
  A. 1 Localized only (localized, NOS)
  B. 2 Regional by direct extension only



Poll 6 - Answer & Rationale
Pericolonic/Percolorectal tissue Invaded-Reg or Local

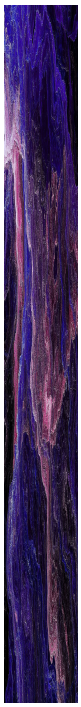
- **Answer:** 1 Localized
- The Ascending colon is partially peritonealized (anterior and lateral surfaces)
- Summary Stage 2018 - READ THE NOTES!!!!!
- Note 7: …For partially peritonealized sites (See Note 6), "pericolonic/pericolorectal tissue" may indicate invasion of either non-peritonealized (localized, code 1) or peritonealized tissue (regional, code 2)
  - Check for mention of serosa/peritoneum in the operative report and/or pathology report final diagnosis or gross description to determine the correct code. Again, if other descriptions besides "pericolonic/pericolorectal tissue" are used, assign localized (code 1) or regional (code 2) based on the terminology used
  - If the pathologist does not further describe the "pericolic/perirectal tissues" as either "non-peritonealized pericolic/perirectal tissues" vs "peritonealized pericolic/perirectal tissues" fat and the gross description does not describe the tumor relation to the serosa/peritoneal surface, and it cannot be determined whether the tumor arises in a peritonealized portion of the colon, code Localized.

EOD Primary Tumor Code 500; SS 2
Appendix and Colon and Rectum

SS	EOD	Description
2	500	Mesothelium Serosa Tunica serosa Invasion of/ through visceral peritoneum

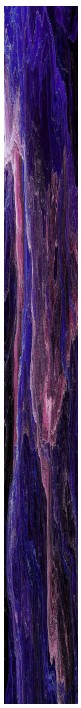
Note 7: Colon and Rectum: Tumors characterized by involvement of the serosal surface (visceral peritoneum) by direct extension or perforation in which the tumor cells are continuous with the serosal surface **through inflammation** are EOD code 500/SS code 2

No similar note in EOD Primary Tumor in the appendix schema, but the same principle applies.



Appendix EOD Primary Tumor 600; SS 7

- For mucinous tumors only (ICD-O-3 codes 8480/3, 8481/3, and 8490/3 only)
  - Peritoneal involvement confined within right lower quadrant
    - WITHOUT further local extension

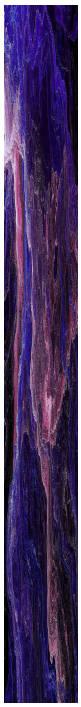


EOD Primary Tumor 600-750; SS 2 and 7

Structure Involved	C180	C181	C182	C183	C184	C185	C186	C187	C199	C209
Abdominal wall	600	700	600	600	600	600	600	600	600	600
Adrenal (suprarenal) gland	700	750	700	700	700	700	700	700		
Anus/anal canal										600
Bile ducts				600	600	600				
Bladder	700	750	700	700	700	700	700	700	700	700
Bladder (females only)										700
Bladder (males only)										600
Bone(s) of pelvis										700
Cervix										700
Colon via serosa									700	
Cul de sac (rectouterine pouch)								700	600	600
Diaphragm	700	750	700	700	700	700	700	700		
Ductus deferens										600

EOD 600 = SS2
EOD 700* = SS2/ 7
EOD 750 = SS7

★ Appendix

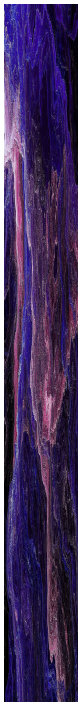


EOD Primary Tumor 600-750; SS 2 and 7

Structure Involved	C180	C181	C182	C183	C184	C185	C186	C187	C199	C209
Fallopian tube(s)	700	750	700	700	700	700	700	700	700	
Fistula to skin	700	750	700	700	700	700	700	700		
Further contiguous extension	700	750	700	700	700	700	700	700	700	700
Gallbladder	700	750	700	600	600	600	700	700		
Greater omentum	600	700	600				600	600		600
Kidney	700	750		600	600	600				
Kidney Right			600							
Kidney Left							600			
Liver	700	750		600	600	600				
Liver Right Lobe			600							
Other segment(s) of colon via serosa	700	750	700	700	700	700	700	700		
Ovary(ies)	700	750	700	700	700	700	700	700	700	
Pancreas				600	600	600				

EOD 600 = SS2
EOD 700 = SS2/7
EOD 750 = SS7

Appendix



EOD Primary Tumor 600-750; SS 2 and 7

Structure Involved	C180	C181	C182	C183	C184	C185	C186	C187	C199	C209
Pelvic wall + (plexuses C209)							600	600	600	600
Perineum, perianal skin										700
Prostate									700	600
Rectovaginal septum										
Rectovesical fascia (males only)										600
Retroperitoneum (excluding fat)	600	700	600	600	600	600	600	600	600	600
Sacrum, Sacral plexus										700
Seminal vesicle(s)										600
Skeletal muscles of pelvic floor									700	600
Small intestine										
Small intestine	600	700	600	600	600	600	600	600	600	600
Spleen				600	600	600	600			
Stomach				600	600	600				

EOD 600 = SS2
EOD 700 = SS2/7
EOD 750 = SS7

Appendix

EOD Primary Tumor 600-750; SS 2 and 7

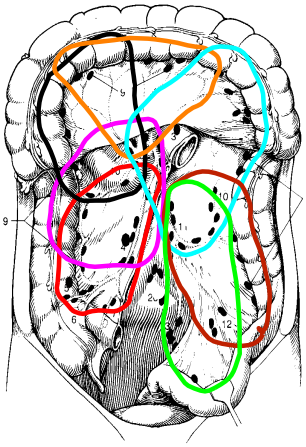
Structure Involved	C180	C181	C182	C183	C184	C185	C186	C187	C199	C209
Ureter	700	750		700	700	700		700	700	
Ureter Right			600							
Ureter Left							600			
Urethra										700
Uterus	700	750	700	700	700	700	700	700		
Vagina									700	600

EOD 600 = SS2
EOD 700 = SS2/7
EOD 750 = SS7

★ Appendix

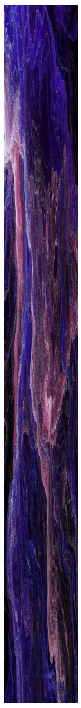
Regional LNs by Colon Segment

Cecum
Ascending
Hepatic flexure
Transverse
Splenic flexure
Descending
Sigmoid



Artwork by AFritz & Associates.

Code EOD 300 -- all sites
Regional nodes, NOS including mesenteric, NOS

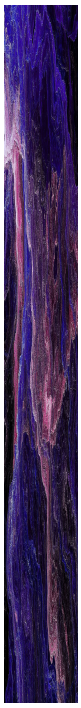


EOD Regional Nodes

- Code only regional nodes and nodes, NOS in this field. Distant nodes are coded in EOD Mets
- For Colon and Rectum **ONLY**
  - Any unnamed nodes that are removed with a colon or rectal resection are presumed to be RLNs and are included in the EOD Regional Nodes code 300
- For Appendix, when RLNS are involved, but you don't know which ones, assign EOD Regional Nodes code 800
- Code 200 in the Colon and Rectum schema and code 400 in the Appendix schema is used when
  - Tumor deposits are present WITHOUT positive lymph nodes
  - If there are also positive lymph nodes, code 300 (both schema)

Regional Lymph Nodes: C18.0 -18.7 EOD 300, SS at least 3

	C18._ subsite							
Regional LN	**C180**	**C181**	**C182**	**C183**	**C184**	**C185**	**C186**	**C187**
Anterior cecal (prececal)	X	X						
Cecal, NOS	X	X						
Colic (left)						X	X	X
Colic (middle-right branch)			X					
Colic (middle)				X	X	X		
Colic (right)	X	X	X	X				
Ileocolic	X	X	X	X				
Mesenteric (inferior)						X	X	X
Periappendiceal	X							
Posterior cecal (retrocecal)	X	X						
Rectal (superior) (hemorrhoidal)								X
Rectosigmoid								X
Sigmoid							X	
Sigmoid (sigmoidal) (sigmoid mesenteric)								X
Superior rectal (hemorrhoidal)								X



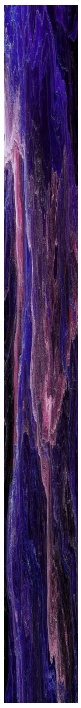
Regional Lymph Nodes – C19.9 & C20.9 EOD 300, SS at least 3

Lymph Node	C19.9	C20.9
Hemorrhoidal (middle, superior)	X	X
Iliac (hypogastric, internal, obturator)*		X
Lateral sacral (laterosacral)		X
Mesenteric (inferior)	X	X
Mesorectal	X	X
Middle sacral (promontorial) (Gerota's node)		X
Pericolic	X	
Perirectal	X	X
Presacral		X
Rectal (inferior)		X
Rectal (middle, superior)	X	
Sacral, NOS		X
Sigmoid (mesenteric)	X	

*For rectum, see EOD Mets for common iliac, external iliac, and iliac NOS

Poll 7 – EOD Regional Nodes

- **Scenario:**
  - CT scan of Abdomen and Pelvis: 1.2cm transverse colon tumor that extends into surrounding pericolonic tissues. There is also right lung metastasis and liver metastasis seen on CT. Patient has liver biopsy performed on 04-19-2021 which shows adenocarcinoma consistent with metastasis from colon primary. No further resection done.
- **Question:** How would you assign EOD Regional Nodes?
  A. 000 No RLN mets
  B. 300 Regional lymph nodes involved
  C. 999 Unknown if RLNs involved



Poll 7 – Answer & Rationale
EOD Regional Nodes

- **Answer:** 999
- **Rationale:** EOD Manual, instruction 8 for EOD Regional Nodes

8. **Code EOD Regional Nodes 000 (negative) instead of 999 (unknown) when all 3 conditions are met**:

- No mention of regional lymph in physical exam, pretreatment diagnostic testing or surgical exploration
- Patient has localized disease
- Patient receives standard treatment for localized disease, or patient is offered standard treatment, but refuses it

These guidelines apply only to **localized** cancers. Assign code 999 when there is reasonable doubt that the tumor is localized

Distant Mets

Appendix; Colon and Rectum

- SS2018 provides a list of distant sites and distant LNs, as well as distant mets, NOS

Appendix

EOD codes are based on the presence of:

- intraperitoneal acellular mucin
- intraperitoneal mets (peritoneal carcinomatosis),
- distant LN mets
- nonperitoneal mets

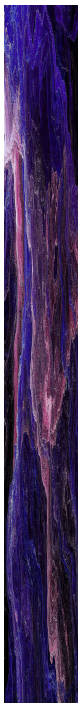
  If there are specific mets documented not listed in codes 10, 30, 40, or 50, assign code 50

Colon and Rectum

EOD codes are based on whether there is a single or multiple metastatic site(s), and involvement of the peritoneum

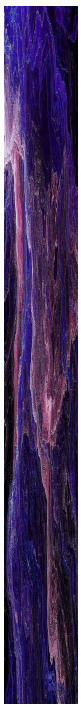
Distant LNs are listed for the colon, rectosigmoid, and rectum

Use the EOD primary tumor descriptions if you are unsure whether the involved site is distant (If it is listed there, it is not distant!)



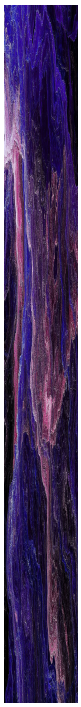
SS2018 Distant Sites: C18._, C19.9, C20.9

	Adrenal gland	Bladder	Bone(s) of pelvis	Cervix	Colon via serosa	Cul de sac	Diaphragm	Fallopian tube	Fistula to skin	Gallbladder	Kidney, right	Liver	Other segments of colon via serosa	Ovary	Perineum, perianal skin	Prostate	Sacral plexus	Sacrum	Skeletal muscles pelvic floor	Ureter	Ureter, right	Urethra	Uterus	Vagina
C180	X	X					X	X	X	X	X	X	X	X							X		X	
C181	X	X					X	X	X	X			X	X									X	
C182	X	X					X	X	X	X			X	X									X	
C183-5	X	X					X	X	X	X			X	X						X			X	
C186	X	X					X	X	X	X			X	X									X	
C187	X	X				X	X	X	X	X			X	X						X			X	
C199		X			X			X						X		X			X	X				X
C209		**F**	X	X											X		X	X		X		X	X	



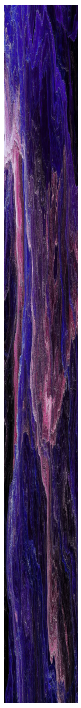
SS2018 Distant LNs: C18._, C19.9, C20.9

Distant LN	C180	C181	C182	C183	C184	C185	C186	C187	C199	C209
Colic (left)										X
Hemorrhoidal, inferior									X	
Common iliac	X		X	X	X	X			X	X
External iliac	X		X	X	X	X			X	X
Hypogastric	X		X	X	X	X			X	
Internal iliac	X		X	X	X	X			X	
Obturator	X		X	X	X	X			X	
Iliac, NOS	X		X	X	X	X			X	X
Inferior mesenteric	X	X	X	X	X					
Para-aortic	X		X	X	X	X	X	X		
Rectal, inferior									X	
Retroperitoneal	X		X	X	X	X	X	X		
Superior mesenteric	X	X	X	X	X	X	X	X	X	X



Colon and Rectum: EOD Mets	
Code	**Description**
00	No distant metastasis
	Unknown if distant metastasis
10	SINGLE distant lymph node chain
20	SINGLE distant organ (except peritoneum)
30	Single distant lymph node chain
	WITH single distant organ (except peritoneum)
	Metastasis to MULTIPLE distant lymph node chains
	WITH or WITHOUT single distant organ (except peritoneum)
40	MULTIPLE distant organs (except peritoneum)
	WITH or WITHOUT distant lymph node(s)
50	Peritoneal surface metastasis (peritoneum)
	WITH or WITHOUT distant lymph node(s) or distant organ(s)
70	Carcinomatosis
	Distant lymph node(s), NOS
	Not specified as single or multiple chains
	Distant metastasis, NOS
	Not specified as single or multiple organs
99	Death Certificate Only

AJCC 8th ed. Colon and Rectum



Colorectal Cancer Chapter 20

- Includes
  - Adenocarcinomas
  - High grade neuroendocrine carcinomas
  - Squamous carcinomas
- Does not include:
  - Appendix
  - Anal carcinoma
  - WD Neuroendocrine tumors of colorectum (carcinoid)

Clinical Staging

- H&P
- Endoscopy
  - Sigmoidoscopy, colonoscopy, endoscopic ultrasound (EUS), etc.
- Radiology
  - CXR, CT C/A/P, MRI, (CT)/PET
  - Barium enema

Pathological Staging

- cTNM + Op findings + path from resected specimen
- Pre-treatment CEA recommended
- Surgeries
  - Polypectomy
  - Local excision
  - Segmental resection
  - Partial colectomy
  - Total colectomy

T Categories

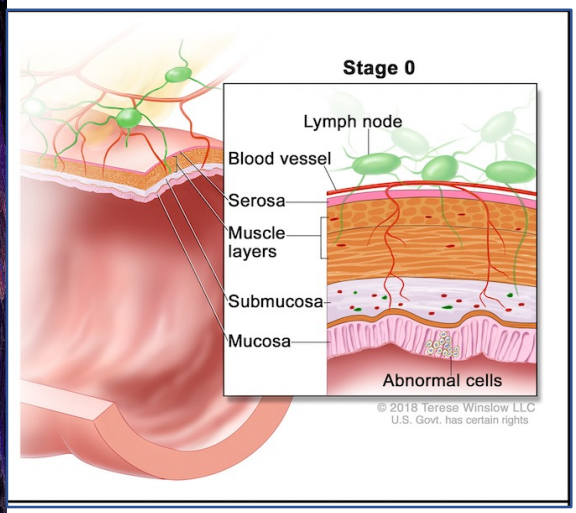
- TX and T0 included
- Tis includes invasion of lamina propria
- T1-3 used for specific level of invasion of wall/beyond wall
- T4 has subcategories for invasion through serosa and adherence/invasion of adjacent structures

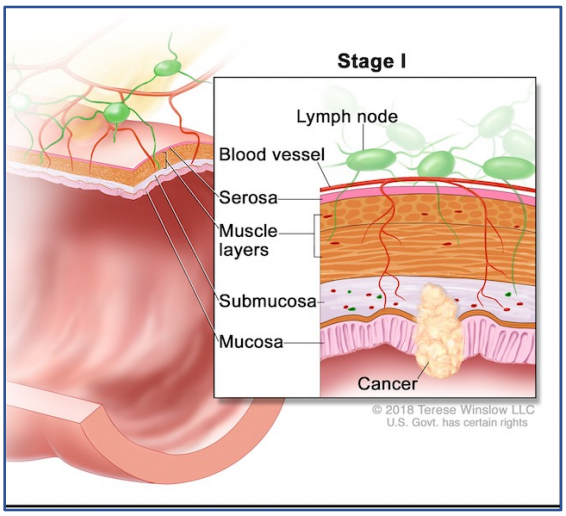
N Categories

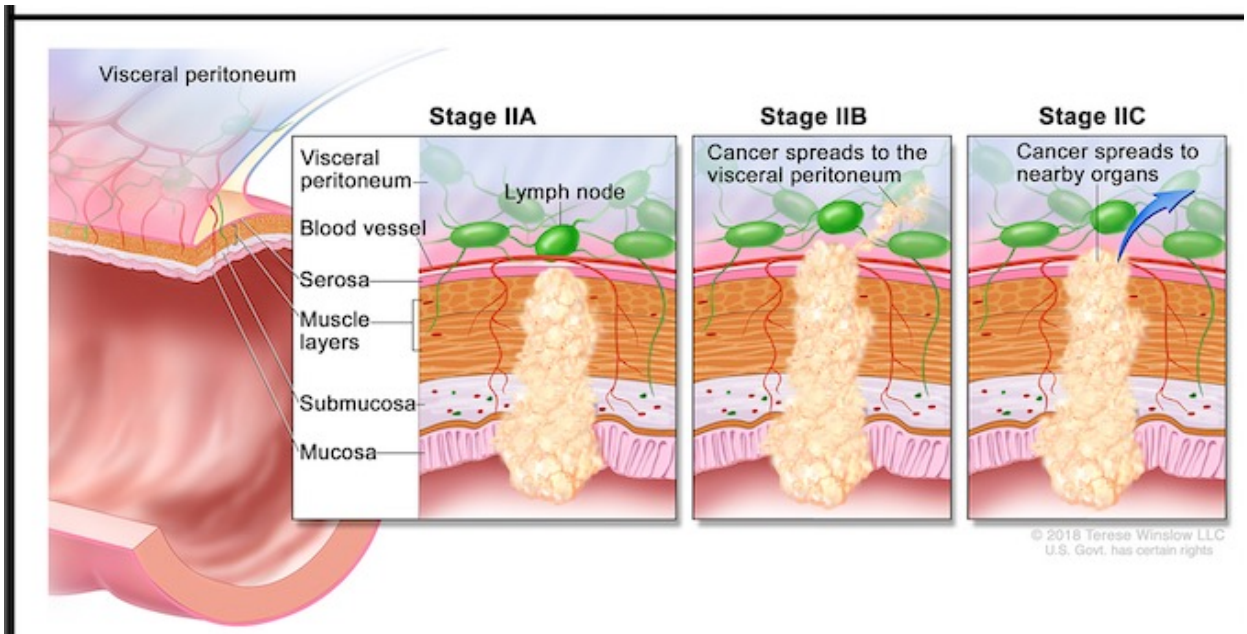
- N based on # RLNs involved
- N1 includes 3 subcategories based on number of LNs (1 vs. 2-3) involved **OR** presence of tumor deposits
- N2 has 2 subcategories based on number of LNs involved (4-6 vs. 7+)

M Categories

- Three subcategories of M1 based on
  - Number of organs with mets
  - Peritoneal mets






Visceral peritoneum
Stage IIA
Visceral peritoneum
Lymph node
Blood vessel
Serosa
Muscle layers
Submucosa
Mucosa
Stage IIB
Cancer spreads to the visceral peritoneum
Stage IIC
Cancer spreads to nearby organs
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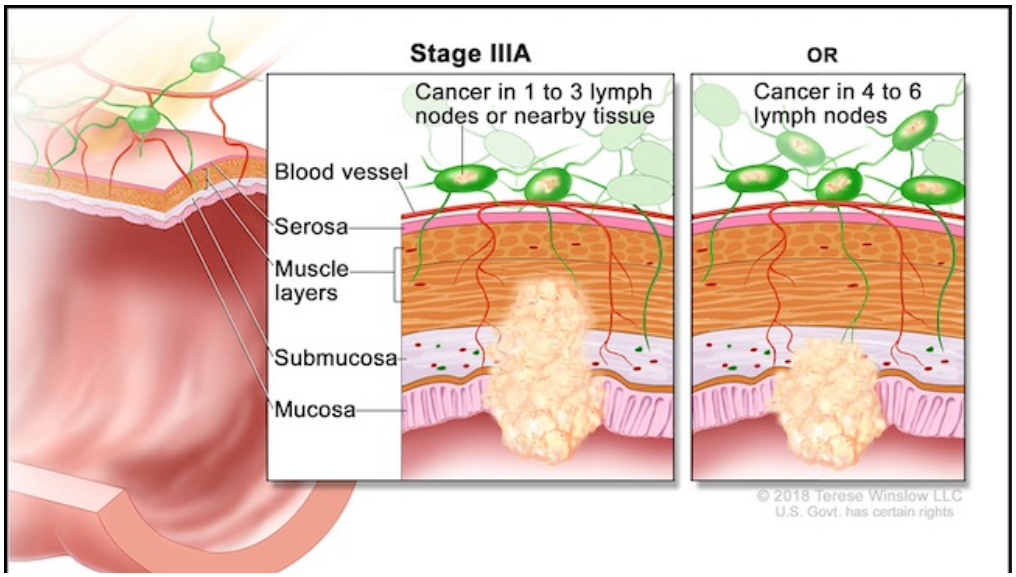
Stage IIIA
Cancer in 1 to 3 lymph nodes or nearby tissue
OR
Cancer in 4 to 6 lymph nodes
Blood vessel
Serosa
Muscle layers
Submucosa
Mucosa
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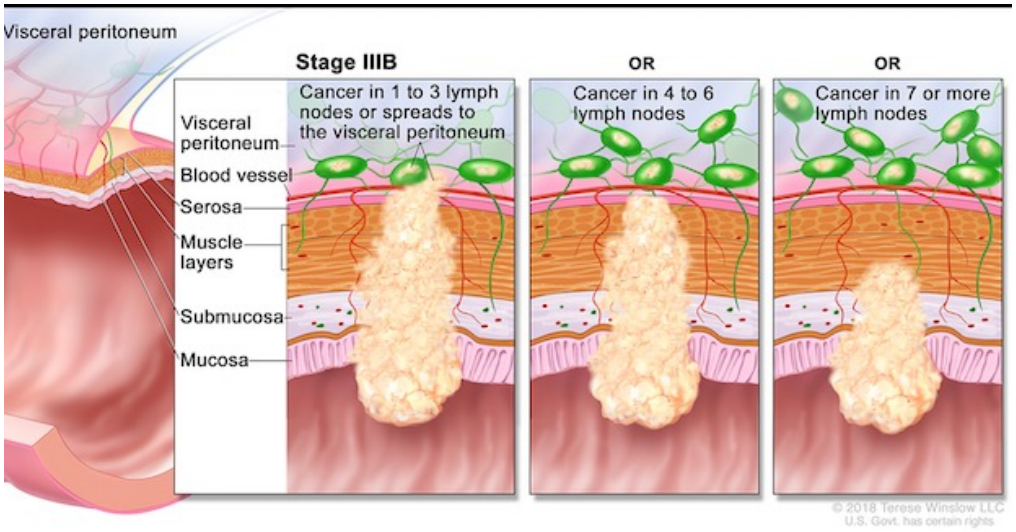
Visceral peritoneum
Stage IIIB
OR
OR
Visceral peritoneum
Blood vessel
Serosa
Muscle layers
Submucosa
Mucosa
Cancer in 1 to 3 lymph nodes or spreads to the visceral peritoneum
Cancer in 4 to 6 lymph nodes
Cancer in 7 or more lymph nodes
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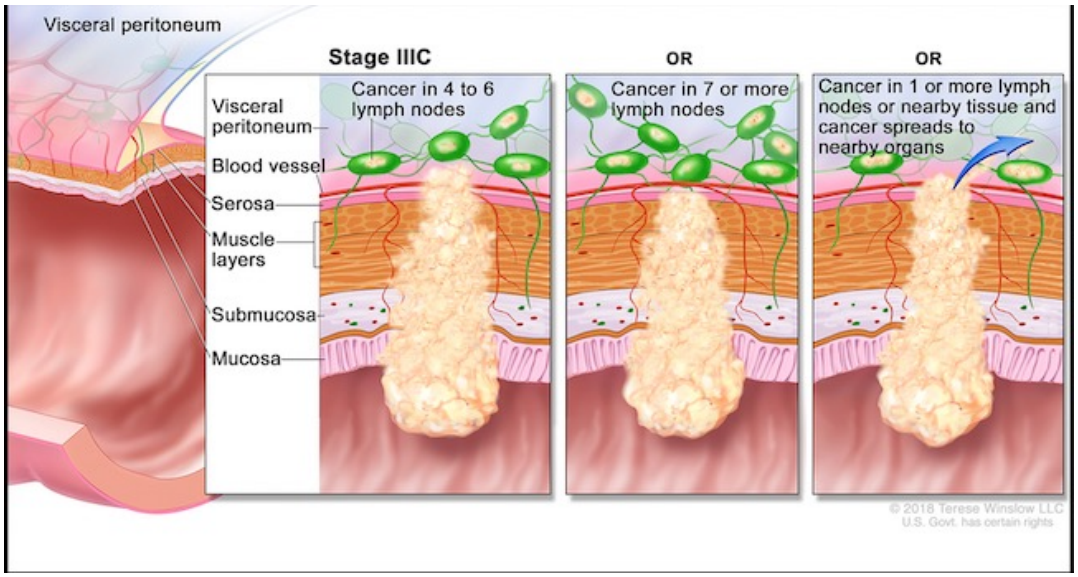
Visceral peritoneum
Stage IIIC
OR
OR
Visceral peritoneum
Blood vessel
Serosa
Muscle layers
Submucosa
Mucosa
Cancer in 4 to 6 lymph nodes
Cancer in 7 or more lymph nodes
Cancer in 1 or more lymph nodes or nearby tissue and cancer spreads to nearby organs
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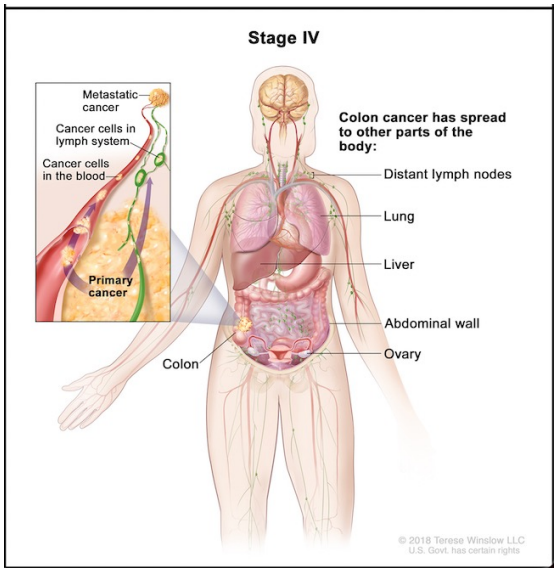
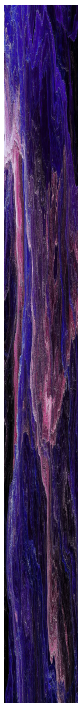


Poll 8 – AJCC X vs Blank

- **Scenario:**
  - Rectal cancer 5.0cm from the anal verge on imaging; the cancer is stated T3/4 - with possible involvement of prostate and clinically positive mesorectal lymph nodes.
  - Patient was presented to Tumor Board; managing physician, medical oncologist, and radiation oncologist state: T3/4 N1 stage IIIB.

- **Question:** How would you assign AJCC cT category?
  A. cT3
  B. cT4
  C. cTX
  D. cT BLANK



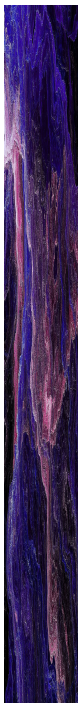
Poll 8 – Answer & Rationale
AJCC X vs Blank

- **Answer:** cT BLANK

- **Rationale:**
  - The physician assessed the tumor with scans, but they just were not sure if the tumor was a T3 or a T4. This is an example of uncertain information. An X would indicate that the tumor was not assessed. By leaving the cT category blank, this indicates that the physicians were able to assess this tumor, but the documentation wasn't clear enough or specific enough to assign the category.
  - AJCC Curriculum for Registrars lesson 9: Correct T category for uncertain information for Registrars https://www.facs.org/quality-programs/cancer/ajcc/staging-education/registrar/curriculum

Poll 9 – cN Unknown # of Nodes +

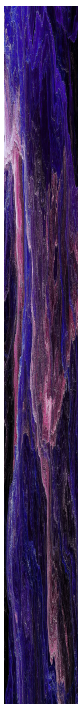
- **Scenario:**
  - CT scan of Abdomen and Pelvis: 1.2cm transverse colon that extends into surrounding pericolonic tissues. There are **enlarged pericolic lymph nodes consistent with involvement**. There is also right lung metastasis and liver metastasis seen on CT. Patient has liver biopsy performed on 04-19-2021 which shows adenocarcinoma consistent with metastasis from colon primary. No further resection done.)
- **Question:** How would you assign AJCC cN category? [**enlarged pericolic lymph nodes consistent with involvement.]**
  A. cN1 One to three regional lymph nodes are positive (tumor in lymph nodes measuring ≥0.2mm), or any number of tumor deposits are present and all identifiable lymph nodes are negative
  B. cN2 Four or more regional nodes are positive
  C. cNX
  D. cN BLANK



Poll 9 – Answer & Rationale
cN Unknown #of Nodes +

- **Answer:** cN BLANK

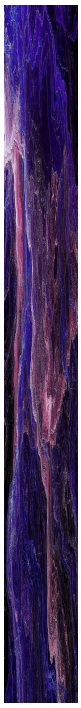
- **Rationale:** Nodes are positive, but it is unknown the exact number of nodes positive. When using data for analysis, you cannot mix in this type of uncertain data without skewing the results. To make data useful, it must be accurate.



Poll 10 – cT after Colonoscopy

- **Scenario:**
  - Patient presents to facility for colonoscopy which shows a mass in the cecum, biopsy is positive for invasive adenocarcinoma. No further workup is done prior to taking the patient to definitive surgery.

- **Question:** How would you assign cT?
  A. cTX
  B. BLANK

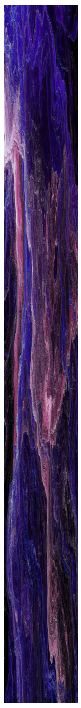


Poll 10 – Answer & Rationale
cT after Colonoscopy

- **Answer:** cTX
- **Rationale:** The colonoscopy does not provide enough information to access how far the tumor extended through the wall of the colon.
  - AJCC Curriculum for Registrars https://www.facs.org/quality-programs/cancer-programs/american-joint-committee-on-cancer/staging-education/registrar/
    - Refer to Lesson 23

Poll 11 – cT after Colonoscopy & Scans

- **Scenario:**
  - Patient undergoes colonoscopy with biopsy from the sigmoid colon (tumor extent not documented in endoscopy report); staging CT follows which visualizes the sigmoid colon tumor, but the extent of invasion is not documented on the scan; physician did not assign cTNM prior to resection.
- **Question:** How would you assign cT?
  A. cTX
  B. BLANK

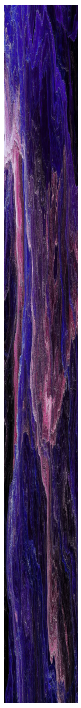


Poll 11 – Answer & Rationale
cT after Colonoscopy

- **Answer:** cTX
- **Rationale:** Colonoscopy is generally not adequate for evaluating the depth of invasion and the CT did not provide information regarding the depth of invasion; however, if there is the possibility the physician has other information to which you do not have access, assign cT blank

Poll 12 – AJCC T Category
Polypectomy – Part of dx Workup

- **Scenario:**
  - Colonoscopy: screening colonoscopy found 25mm polyp removed by piecemeal mucosal resection using snare.
  - Pathology: Poorly diff Adenocarcinoma arising in a serrated polyp invading the submucosa. There is no mention of margins on the path report.
  - Scans: No evidence of adenopathy/mets and no mention of colon mass
  - 03-15-2020 Hemicolectomy
- **Question:** How is the cT category assigned?
  A. cT1
  B. cTX
  C. BLANK



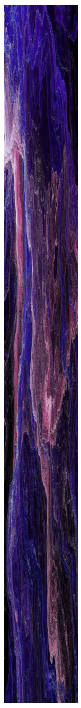
Poll 12 – Answer & Rationale
Polypectomy – Part of dx Workup-

- **Answer:** cT1

- **Rationale:** Although the polyp was surgically removed, the Information from this surgery can be used for clinical staging because the polypectomy was not the definitive treatment; it was part of the diagnostic workup.

Poll 13 – AJCC T
Polypectomy done as Treatment

- **Scenario:**
  - Colonoscopy: screening colonoscopy found pedunculated polyp removed with snare polypectomy.
  - Pathology: Invasive Poorly diff Adenocarcinoma arising in a pedunculated polyp. There is no mention of margins on the path report.
  - Scans: No evidence of adenopathy/mets and no mention of colon mass
  - No further treatment recommended.
- **Question:** How is the cT category assigned?
  A. cT1
  B. cTX
  C. BLANK



Poll 13 – Answer & Rationale Polypectomy Done as Treatment

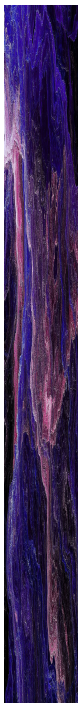
- **Answer:** cT would be left BLANK

- **Rationale:** The clinical staging would be BLANK, the cancer was not known or suspected prior to surgical resection. The snare polypectomy was meant to be definitive treatment and the information from the polypectomy would be used for pathological staging only. Pathologic stage pT1 pNX cM0 Stage 99

Poll 14– Bizarre Polypectomy Behavior

- **Scenario:**
  - Sigmoid Colon Polypectomy: invasive adenocarcinoma limited to the lamina propria, margins clear
  - Physician stated no further treatment needed
  - Physician assigned pTis cN0 cM0 Stage 0

- **Question:** How will you assign behavior code?
  A. /3
  B. /2



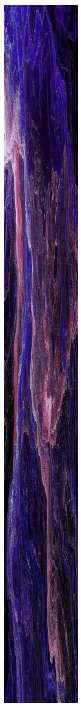
Poll 14 - Answer & Rationale Behavior

- **Answer:** /3 invasive
- **Rationale**
  - Summary Stage 2018 Coding Manual v3.0 Page 146
    - Note 4: For the following, AJCC 8th edition stages these as in situ tumors. SS2018 stages these as localized (behavior code 3)
      - Intramucosal, NOS
      - Lamina propria
      - Mucosa, NOS
      - Confined to, but not through muscularis mucosa
  - Histology/Behavior:8140/3
  - SEER Summary Stage: 1 Localized
  - AJCC: pTis cN0 cM0 Stage 0
  - EOD Primary Tumor: 050

In AJCC, Tis is assigned to lesions that **invade** the lamina propria as long as they do not penetrate **through** the muscularis mucosa because these are associated with a negligible risk for metastases. Tis does not mean the behavior is /2. (AJCC page 256)

AJCC 9th Version Appendix

- Excludes Well-differentiated neuroendocrine tumor (carcinoid) of the appendix
- (Use Chapter 32 – Neuroendocrine Tumors of the Appendix)



Clinical Staging

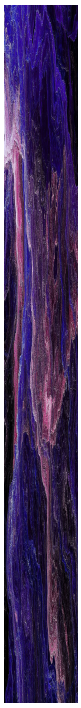
- Medical history
- H&P
- Imaging
  - CT C/A/P; MRI; PET;PET/CT
- Endoscopy
- Biopsy
- Surgical exploration w/out resection

Pathological Staging

- cTNM + Op findings + path from resected specimen
- Surgeries
  - Appendectomy
  - Rt hemicolectomy (when indicated after appendectomy)

T Categories

- TX and T0 included
- Tis includes invasion of lamina propria or extension into muscularis mucosa
- Tis (LAMN) includes confined tumor to muscularis propria
- T1-3 used for specific wall layer invaded, including into subserosa/mesoappendix
- T4 has subcategories for invasion through serosa (including acellular mucin or mucinous epithelium involving serosa and adherence/invasion of adjacent structures



N Categories

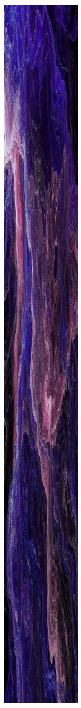
- N based on # RLNs involved
- N1 includes 3 subcategories based on number of LNs (1 vs. 2-3) involved **OR** presence of tumor deposits w/o LN mets
- N2 based on number of LNs involved (4+)

M Categories

- One subcategory of cM1 for non peritoneal mets
- Three subcategories of pM1 for
  - Intraperitoneal acellular mucin
  - Intraperitoneal mets
  - Non peritoneal mets

Poll 15 – AJCC-Incidental Finding

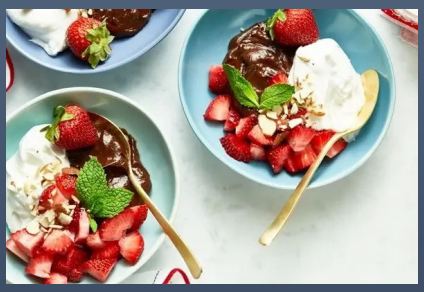
- **Scenario:**
  - 2023: Patient presents with severe RLQ abdominal pain; CT was compatible with acute uncomplicated appendicitis; laparoscopic appendectomy performed; op note states inflammatory changes w/ significantly distended appendix.
  - Pathology: Appendix+ G2 Adenocarcinoma invading the muscularis propria
- **Question:** How is the cT category assigned?
  A. cT2
  B. cT BLANK



Poll 15 – Answer & Rationale AJCC-Incidental Finding

- **Answer:** cT BLANK
- **Rationale:** Version 9 AJCC Cancer Staging Protocol for Appendix, Common staging scenarios (Note CSS) 1) Undetected cancer in an appendectomy specimen. 'Pathological staging is assigned by the managing physician for this incidental finding. There is no clinical staging. '

Fabulous Prizes



CE Certificate Quiz/Survey

CE Phrase

- Intramucosal

Link

- https://survey.alchemer.com/s3/7032817/Lower-GI-2023-Part-2

Coming UP…

IT Worked for Me: In"FUN"matics in the Cancer Registry

- Guest Host: Ronda Broome, Lisa Landvogt, Kelli Merriman
- 7/13/2023

Melanoma 2023

- Guest Host: Janine Smith
- 8/3/2023

Thank you!

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amartin@naaccr.org